

Indiana State Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012288 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED C 09/29/2015 |
| NAME OF PROVIDER OR SUPPLIER LAMPLIGHT INN OF FORT WAYNE | | STREET ADDRESS, CITY, STATE, ZIP CODE 300 E WASHINGTON BLVD FORT WAYNE, IN 46802 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| R 000 | <p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00182349.</p> <p>This visit included a Quality Assurance Walk Through Survey.</p> <p>Complaint IN00182349 -Unsubstantiated, due to lack of evidence.</p> <p>Survey Dates: September 28 & 29, 2015</p> <p>Facility number: 012288 Provider number: N/A AIM number: N/A</p> <p>Census bed type: Residential: 133 Total: 133</p> <p>Census payor type: Medicaid: 85 Other: 48 Total: 133</p> <p>Sample: 3</p> <p>Lamplight Inn of Fort Wayne was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00182349 and the Quality Assurance Walk Through Survey.</p> | R 000 | | |

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE